MassHealth
Commonwealth of Massachusetts
EOHHS
www.mass.gov/masshealth

Medical Benefit Request Instruction Page

Please read these instructions before you fill out the application.

Dear Applicant:

This is your application package for **MassHealth**, the **Children's Medical Security Plan (CMSP)**, and **Healthy Start**. MassHealth gives health-care coverage and helps pay for health-insurance premiums for families, children, and individuals. The kind of coverage you get depends on your family size, income, and other circumstances. CMSP gives health-care coverage for children under the age of 19 who are not eligible for MassHealth. After your application is filled out and reviewed, **you will be given the most complete coverage that you qualify for.**

Generally, this package is for people who live in Massachusetts, are not living in or about to go into a nursing home, and are under age 65. This package may also be used by people of any age who are parents of children under age 19, or who are adult relatives living with and taking care of children under age 19 when neither parent is living in the home, or who are disabled and work 40 or more hours a month. If this package is not for you, call 1-888-665-9993 (TTY: 1-888-665-9997 for people with partial or total hearing loss).

This package contains:

- one application (Medical Benefit Request) used for MassHealth, CMSP, and Healthy Start
- a booklet that explains who is eligible for MassHealth, what the income rules are, and what medical services you can get under MassHealth
- a fact sheet that explains CMSP
- a Primary Language Identification Form
- information about voter registration (You do not need to register to vote to get MassHealth.)
- a MassHealth Eligibility Representative Designation Form (If you want someone to act on your behalf, you can use this form to tell us who this person is.)

Please list only one family group on an application. A family group can be parents, stepparents, or adoptive parents of any age and any of their children under age 19 who are all living together. If no parents are living at home, a family group may be siblings under age 19, or children under age 19 and an adult related by blood, adoption, or marriage, or a spouse or former spouse of one of those relatives who are all living together. A family group can also be an individual or a married couple who are living together with no children under the age of 19. If more than one family group lives in your home, each family group must fill out a separate application. MassHealth will send all eligibility notices to the person who is your "head of household," and to your eligibility representative, if you have one.

Please read the enclosed MassHealth Member Booklet carefully before you fill out the application. Keep the booklet. It may answer questions you have later.

When you fill out the application, be sure to:

- Answer **all** questions, and fill out all sections and any supplements that apply to you and your family.
- Sign and date the application. The head of household, all applicants aged 18 or older, and all parents of any age who have children living with them must sign.
- Send proof of all income, like copies of two recent pay stubs.
- Send proof of your HIV-positive status only if you want to see if you are eligible for MassHealth because you are HIV positive.
- Send a copy of both sides of all immigration cards (or other documents that show immigration status) for every family member who is not a U.S. citizen and who is applying for MassHealth, except for MassHealth Limited, CMSP, or Healthy Start. (See Supplement D.)
- Send a copy of both sides of all health-insurance cards for every family member.

The information you give us is kept confidential, as required by state and federal laws. If you want us to share information about your MassHealth eligibility (including copies of notices we send you) with someone other than your Eligibility Representative, if you have one, please call MassHealth. MassHealth can give you a MassHealth Permission to Share Information Form.

over ►

Sign the application after you fill it out. Send the application and all other needed papers to:

MassHealth Enrollment Center
Central Processing Unit
P.O. Box 290794
Charlestown, MA 02129-0214

If you have any questions about this application or the information you need to send, please call MassHealth at 1-888-665-9993 (TTY: 1-888-665-9997 for people with partial or total hearing loss). **For questions about CMSP and Healthy Start, please call 1-800-531-2229.**

When we get your filled-out, signed, and dated application, we will review it. If more information is needed, we will write or call you. **Once we get all needed information, we will make a decision about your eligibility. We will send you a written notice about this decision.**

MassHealth
Commonwealth of Massachusetts
EOHHS
www.mass.gov/masshealth

Medical Benefit Request

For office use only

Screener I.D.: _____

Date received:

Interpreter code: _____

Referred by: _____

Entry date: _____

Supplement C ☐

This is an application for **MassHealth,** the **Children's Medical Security Plan (CMSP),** and **Healthy Start.** Please answer **all** questions, and fill out all sections and any supplements that apply to you and your family. You do not have to be a U.S. citizen to get MassHealth. Please print clearly. If you need more space to finish any section on this form, please use a separate sheet of paper, and attach it to the application.

Head of Household

HOH

1.

Last name	First name	MI	Street address

City	State	Zip	Mailing address *(if different from street address or if living in a shelter)* ☐ homeless

Is this person applying? ☐ yes ☐ no	If **yes**, is this person a U.S. citizen? ☐ yes ☐ no	Social security number*	Date of birth / /	Sex ☐ M ☐ F	Race *(optional)*

Spoken language choice	Written language choice	Ethnicity *(optional)*	Telephone numbers *(List work number only if we can call you at work.)* Home: ( ) Work: ( )

Other Family Members

▶ List all other members of your family group. *Do not repeat head of household information in this section.* See instruction page for description of a family group.

2.

Last name	First name	MI	Is this person applying? ☐ yes ☐ no	If **yes**, is this person a U.S. citizen? ☐ yes ☐ no	Social security number*	Date of birth / /

Sex ☐ M ☐ F	Race *(optional)*	Spoken language choice	Written language choice	Ethnicity *(optional)*	Relationship to head of household

3.

Last name	First name	MI	Is this person applying? ☐ yes ☐ no	If **yes**, is this person a U.S. citizen? ☐ yes ☐ no	Social security number*	Date of birth / /

Sex ☐ M ☐ F	Race *(optional)*	Spoken language choice	Written language choice	Ethnicity *(optional)*	Relationship to head of household

4.

Last name	First name	MI	Is this person applying? ☐ yes ☐ no	If **yes**, is this person a U.S. citizen? ☐ yes ☐ no	Social security number*	Date of birth / /

Sex ☐ M ☐ F	Race *(optional)*	Spoken language choice	Written language choice	Ethnicity *(optional)*	Relationship to head of household

5.

Last name	First name	MI	Is this person applying? ☐ yes ☐ no	If **yes**, is this person a U.S. citizen? ☐ yes ☐ no	Social security number*	Date of birth / /

Sex ☐ M ☐ F	Race *(optional)*	Spoken language choice	Written language choice	Ethnicity *(optional)*	Relationship to head of household

Pregnancy

PRG

▶ Are you or any family member pregnant? . . . . . ☐ yes ☐ no

Name	Are you or this person pregnant with ☐ 1 baby? ☐ twins? ☐ triplets? If more, how many?_____	Due date / /

American Indian/Alaska Native

Family members under the age of 19 who are Alaska Natives or members of a federally recognized American Indian tribe who get MassHealth Family Assistance may not have to pay any premiums for this coverage.

▶ Are you or any family member who is under the age of 19 an Alaska Native or a member of a federally recognized American Indian tribe? . . . ☐ yes ☐ no

If **yes**, names: _____

*Required, if one has been issued and this person is applying for MassHealth, except for MassHealth Limited, CMSP, or Healthy Start.

HIV Information (optional)

MassHealth may give benefits to people who are HIV positive who might not otherwise be eligible.
Do you or any family member who is HIV positive want to apply for these benefits? . . . . . ☐ yes ☐ no

If **yes**, fill out this section.

☒ **Send proof** of income and HIV-positive status. If proof of HIV-positive status is not attached, you may get benefits for up to 60 days while we wait for proof. For more information, see the MassHealth Member Booklet.

Name(s): _____ _____

For office use only

Working

EIN

Are you or any family member currently working or seasonally employed? . . . . . ☐ yes ☐ no

If **no**, go to the next section *(Not Working)*.
If **yes**, fill out this section.*

☒ **Send proof** of income, like a copy of two recent pay stubs. If self-employed, send a copy of your most recent federal tax return.

Note: If you or any family member work only from time to time, do not fill out this section, but please fill out the next section (*Not Working*).

1. **Name**

For office use only (indicate weekly, biweekly, or monthly)

A. Employer name, address, and telephone number	Type of work *(Check all that apply.)*					
	☐ full-time	☐ day labor	☐ sheltered workshop		$	
	☐ part-time	☐ seasonal	yearly wage: $ _____		$	
	☐ self-employed	yearly wage: $ _____			Hrs.	
Is health insurance offered?** ☐ yes ☐ no	Number of hours per week	Weekly pay before deductions $	Date began getting this amount of pay / /	HID	Hrs.	

B. Employer name, address, and telephone number	Type of work *(Check all that apply.)*					
	☐ full-time	☐ day labor	☐ sheltered workshop		$	
	☐ part-time	☐ seasonal	yearly wage: $ _____		$	
	☐ self-employed	yearly wage: $ _____			Hrs.	
Is health insurance offered?** ☐ yes ☐ no	Number of hours per week	Weekly pay before deductions $	Date began getting this amount of pay / /	HID	Hrs.	

2. **Name**

For office use only (indicate weekly, biweekly, or monthly)

A. Employer name, address, and telephone number	Type of work *(Check all that apply.)*					
	☐ full-time	☐ day labor	☐ sheltered workshop		$	
	☐ part-time	☐ seasonal	yearly wage: $ _____		$	
	☐ self-employed	yearly wage: $ _____			Hrs.	
Is health insurance offered?** ☐ yes ☐ no	Number of hours per week	Weekly pay before deductions $	Date began getting this amount of pay / /	HID	Hrs.	

B. Employer name, address, and telephone number	Type of work *(Check all that apply.)*					
	☐ full-time	☐ day labor	☐ sheltered workshop		$	
	☐ part-time	☐ seasonal	yearly wage: $ _____		$	
	☐ self-employed	yearly wage: $ _____			Hrs.	
Is health insurance offered?** ☐ yes ☐ no	Number of hours per week	Weekly pay before deductions $	Date began getting this amount of pay / /	HID	Hrs.	

Not Working

LTU

Are you (or any family member who is aged 19 or older) **unemployed** (or only working from time to time)? . . . . . ☐ yes ☐ no

If **no**, go to the next section *(Nonworking Income)*.
If **yes**, fill out this section.*

Name

Is this person getting unemployment benefits? . . . . . ☐ yes ☐ no

Has this person worked in the past 12 months? . . . . . ☐ yes ☐ no

If **yes**, how much did this person earn in the past 12 months before taxes and deductions? $_____

Is this person a college student? . . . . . ☐ yes ☐ no

If **yes**, is this person eligible for health insurance from the college? . . . . . ☐ yes ☐ no

If married, is your spouse working 100 hours or more a month? . . . . . ☐ yes ☐ no

*If you need more space, please use a separate sheet of paper, and attach it to the application.

**Check yes even if you cannot get it now.

Please go to the next page. ▶

Nonworking Income

UIN

▶ Do you or any family member have any other income? . . . . . ☐ yes ☐ no

If **no**, go to the next section *(Health Insurance)*.

If **yes**, fill out this section.*

▶ Please describe the source of the income (where it comes from) for each family member. If anyone has more than one source, list on separate lines.

✉ **Send proof.** Some types of other income are:

- alimony
- annuities
- child support
- dividends or interest
- pensions
- rental income
- retirement
- Social Security
- SSI
- unemployment compensation
- veteran's benefits
- trusts
- worker's compensation
- other *(please describe below)*

Name	Type of income (all that apply from list above)	Source (where the income comes from)	Monthly amount before taxes	For office use only
			$	
			$	
			$	
			$	

Health Insurance

Even if you or any family member have other health insurance, MassHealth may be able to help you pay your premiums.

▶ Do you or any family member or absent parent have health insurance, or access to health insurance, including Medicare? . . ☐ yes ☐ no

▶ Do you or any family member or absent parent work for an employer who offers health insurance? . . . . . ☐ yes ☐ no

▶ Did you or any family member leave a job within the last six months that offered health insurance? . . . . . ☐ yes ☐ no

If you answered **yes to any of these three questions**, you must fill out **Supplement A** (the green sheet).

Injury, Illness, or Disability

▶ Do you or any family member have an injury, illness, or disability that has lasted or is expected to last for at least 12 months? . . . . . ☐ yes ☐ no

▶ Have you or any family member had an accident, illness, or injury that someone else might be responsible for? . . . . . ☐ yes ☐ no

▶ Have you or any family member had an accident, illness, or injury that could be covered by someone else's insurance or the family member's own insurance, other than health insurance? . . . . . ☐ yes ☐ no

If you answered **yes to any of these three questions**, you must fill out **Supplement B** (the blue sheet).

Absent Parent

▶ Does any child in the family have a parent who does not live with you? . . . . . ☐ yes ☐ no

If **yes**, you must fill out **Supplement C** (the yellow sheet).

Immigration

The citizenship status of parents does not affect the eligibility of their children.

▶ Is every member of the family *who is applying*, including you, a U.S. citizen? . . . . . ☐ yes ☐ no

If **yes**, go to page 4. If **no**, please fill out **Supplement D** (the orange sheet). If you or any other family member applying for benefits does not fit any of the categories on Supplement D, numbered 1 through 15, you or that family member may apply for only MassHealth Limited or, for a child under age 19, MassHealth Limited and/or CMSP or Healthy Start.

▶ List below the names of family members applying only for MassHealth Limited and/or CMSP or Healthy Start.

Applying for MassHealth Limited and/or CMSP or Healthy Start	For office use only	Applying for MassHealth Limited and/or CMSP or Healthy Start	For office use only

*If you need more space, please use a separate sheet of paper, and attach it to the application.

You must read the next page carefully and sign. ▶

Please read this page carefully, then sign and date the bottom of the page.

This is an application for MassHealth, the Children's Medical Security Plan (CMSP), and Healthy Start.

I give permission for my current and former employers and health insurers to release to MassHealth any and all information they have about my health-insurance coverage and health-insurance coverage for members of my family group. This includes, but is not limited to, information about policies, premiums, coinsurance, deductibles, and covered benefits that are, may be, or should have been available to me or members of my family group.

I give permission to MassHealth to get any records or data to prove any information given on this application and any supplements to it, or other information I give to MassHealth once I am a member. If I or my family is found eligible for MassHealth, CMSP, or Healthy Start, I give permission to MassHealth to get any records about medical services provided through these programs.

I understand that if I am aged 55 or older, that after I die, MassHealth may be able to get back money from my estate.

I understand that if I or any members of my family are in an accident, or are injured in some other way, and get money from a third party because of that accident or injury, we will need to use that money to repay MassHealth for certain medical services provided, as explained in the MassHealth Member Booklet. I also understand that I must tell MassHealth in writing, within 10 days, if I file any insurance claim or lawsuit because of an accident or injury to me or a family member applying for benefits.

I understand that if I or any members of my family are eligible for MassHealth, CMSP, or Healthy Start, I must tell MassHealth of any changes in my or my family's income or employment, family size, health-insurance coverage, and health-insurance premiums, or of changes in any other information I gave on this application and any supplements to it within 10 days of learning of the change.

I also understand that by signing below, I give permission to MassHealth to go after and collect third-party payments for medical care and medical support from the parent of any child under age 19 who is applying for benefits.

If I or any member of my family is eligible for MassHealth, CMSP, or Healthy Start, I understand that I may have to pay a premium set by MassHealth. If I am a certain American Indian or Alaska Native eligible for MassHealth Family Assistance, I may not have to pay any premiums under MassHealth Family Assistance.

I certify that I have read or had read to me the information on this application and on any supplements to it and the information in the MassHealth Member Booklet, and that I understand my rights and responsibilities. I further certify under the penalty of perjury that the information on this application and any supplements to it is correct and complete to the best of my knowledge.

If you are acting on behalf of someone in filling out this application and any supplements to it, the enclosed MassHealth Eligibility Representative Designation Form must also be filled out and sent back with this application. Your signature on this application as an eligibility representative certifies that the information on this application and any supplements to it is correct and complete to the best of your knowledge.

If you think MassHealth's decision about whether you are eligible is wrong, you have the right to appeal. If you are denied benefits, you will get information on how to appeal.

The head of household, all persons aged 18 or older, and all parents of any age who have children living with them who are applying for MassHealth, CMSP, or Healthy Start, must read this page carefully, and sign and date below. If you are signing below as an eligibility representative, a filled-out MassHealth Eligibility Representative Designation Form must also be submitted.

X _____ _____

Signature of applicant or eligibility representative — Date

X _____ _____

Signature of applicant or eligibility representative — Date

X _____ _____

Signature of applicant or eligibility representative — Date

MassHealth Supplement A: Health-Insurance Questions

For office use only. Head of household name: _____ Head of household SSN: _____

Leave this page blank if you answered NO to all the health-insurance questions on page 3.
Fill out this page if you answered YES to any of the three health-insurance questions on page 3.
You do not have to give us absent-parent information if you fill out the "Good Cause" section in Supplement C.

Medicare

HN

▶ Do you or any family member who is applying get Medicare? . . . . . ☐ yes ☐ no

If **no**, go to the next section *(Health Insurance)*.
If **yes**, fill out this section.

1.	Name	Claim number
2.	Name	Claim number

Health Insurance

HN

If you or any family member have health insurance, you may still be able to get MassHealth. Health insurance can be from an employer, an absent parent, a union, a school, or Medicare supplemental insurance, like Medex.

▶ Do you or any family member or absent parent have health insurance, other than Medicare, from an employer or any other source? . . . . . ☐ yes ☐ no

If **no**, go to the next section *(Other Possible Health Insurance)*.
If **yes**, fill out this section.

☒ **Send copies** of both sides of all health-insurance cards. *If you have more than one policy, or if you have other insurance like dental or vision, check here* ☐, *and* ***use the extra sections on the back of this page.***

1.

Policyholder name	Date of birth / /	Social security number*	Insurance company name
Names of covered family members _____ _____ _____ _____		Policy start date / /	Policy number
		Group number (if known)	Employer or union name
		Policy type ☐ individual ☐ couple (two adults) ☐ dual (one adult, one child) ☐ family	Policyholder contribution to premium costs $ _____ per week $ _____ per quarter $ _____ per month

Other Possible Health Insurance

EHI

We may be able to help you buy health insurance from your current or former employer. Please fill out this section if you answer **yes** to either question below, and you **do not** have health insurance.

▶ Do you or any family member or absent parent work for an employer who offers health insurance? . . . . . ☐ yes ☐ no
▶ Did you or any family member leave a job within the last six months that offered health insurance? . . . . . ☐ yes ☐ no

If you need more space, check here ☐, *and* ***use the extra sections on the back of this page.***

1.	Name		Employer telephone number ( )
	Employer name	Employer address	
2.	Name		Employer telephone number ( )
	Employer name	Employer address	

*Required, if obtainable and one has been issued, whether or not this person is applying.

Health Insurance (cont.)

HIN

2.

Policyholder name	Date of birth / /	Social security number*	Insurance company name
Names of covered family members _____ _____ _____ _____		Policy start date / / Group number (if known) Policy type ☐ individual ☐ couple (two adults) ☐ dual (one adult, one child) ☐ family	Policy number Employer or union name Policyholder contribution to premium costs $ _____ per week $ _____ per quarter $ _____ per month

3.

Policyholder name	Date of birth / /	Social security number*	Insurance company name
Names of covered family members _____ _____ _____ _____		Policy start date / / Group number (if known) Policy type ☐ individual ☐ couple (two adults) ☐ dual (one adult, one child) ☐ family	Policy number Employer or union name Policyholder contribution to premium costs $ _____ per week $ _____ per quarter $ _____ per month

Other Possible Health Insurance (cont.)

EHI

3.

Name	Employer telephone number ( )
Employer name	Employer address

4.

Name	Employer telephone number ( )
Employer name	Employer address

*Required, if obtainable and one has been issued, whether or not this person is applying.

MassHealth Supplement B: Injury, Illness, or Disability Questions

For office use only. Head of household name: _____ Head of household SSN: _____

Leave this page blank if you answered NO to all the injury, illness, and disability questions on page 3.

Fill out this page if you answered YES to any of the three injury, illness, and disability questions on page 3.

Injury, Illness, or Disability

PDI/DDU

Fill out this section for you or any family member who has an injury, illness, or disability.

1. Name

For office use only
Supp to DES | Dis type

- Does this person have an injury, illness, or disability that has lasted or is expected to last for at least 12 months? . . . . . ☐ yes ☐ no
- Does this person get money from Social Security for a disability? . . . . . ☐ yes ☐ no
- Has this person ever gotten Supplemental Security Income (SSI)? . . . . . ☐ yes ☐ no
- Is this person legally blind? . . . . . ☐ yes ☐ no

If **yes**, send a copy of the Certificate of Blindness.

2. Name

For office use only
Supp to DES | Dis type

- Does this person have an injury, illness, or disability that has lasted or is expected to last for at least 12 months? . . . . . ☐ yes ☐ no
- Does this person get money from Social Security for a disability? . . . . . ☐ yes ☐ no
- Has this person ever gotten Supplemental Security Income (SSI)? . . . . . ☐ yes ☐ no
- Is this person legally blind? . . . . . ☐ yes ☐ no

If **yes**, send a copy of the Certificate of Blindness.

Accident or Injury

TPR

You must answer the following three questions about you or any family member who needs health care because of an accident or injury.

For office use only

- Are you or any family member applying because of an accident or injury that someone else might be responsible for? . . . . . ☐ yes ☐ no

  If **yes**, names: _____

- Do you or any family member have an injury, illness, or disability that was caused by someone else, or that could be covered by someone else's insurance or the family member's own insurance, other than health insurance (like homeowner's or auto insurance)? . . . . . ☐ yes ☐ no

  If **yes**, names: _____

- Has a lawsuit, a worker's compensation claim, or an insurance claim for an accident or injury been filed for you or any family member who is applying? . . . . . ☐ yes ☐ no

  If **yes**, names: _____

If you need more space, please use the back of this page.

Supplement C: Absent-Parent Questions and Assignment of Rights

Do not fill out this supplement if you answered NO to the absent-parent question on page 3.

Fill out this supplement only if you answered YES to the absent-parent question on page 3.

Absent Parent

PART A—Cooperation

To get MassHealth for you and a child who is living with you, you must cooperate with the Child Support Enforcement Division of the Massachusetts Department of Revenue (DOR) to establish paternity and enforce a medical support order, unless you have Good Cause not to cooperate. You must also assign your rights for medical support to MassHealth. Cooperation means that you may have to give information about the identity, location, and employment of the absent parent, appear for appointments with DOR staff and the Court, submit to paternity testing, give information, and take any other action necessary to help DOR in establishing paternity, and establishing, changing, or enforcing a child medical support order. Good Cause is a legal term that means if you cooperated by giving us information about the absent parent, it would not be in the best interests of the child for any of the reasons listed in PART B—Good Cause—on the next page. If you think that you have Good Cause for not cooperating, fill out PART B—Good Cause—on the next page, and do not fill out PART C—Absent-Parent Information—on the next page.

If you do not want to make a Good Cause claim, and you do not cooperate by filling out PART C—Absent-Parent Information—on the next page, your MassHealth eligibility could be affected.

To get MassHealth only for the child who is living with you and not for yourself, you do not have to cooperate with DOR, assign your rights for medical support to MassHealth, or give information about the absent parent. Also, if a pregnant family member is applying for benefits for an unborn child, you do not need to give us information about the absent parent of the unborn child at this time. This means that you do not have to fill out PART B, C, or D of this supplement for that unborn child. Please read the next paragraph about child-support-enforcement services.

Even if you are applying for MassHealth only for the child who is living with you, you can ask for child-support-enforcement services if you want help getting the absent parent to pay for health insurance or child support for the child. To do this, you can call DOR at 1-800-332-2733, or go to www.mass.gov/dor and click on "Child Support." The child's MassHealth coverage will not be affected if you choose to ask for these services or not. If you ask for these services, you will have to cooperate with DOR.

Please go to page 8.

Supplement C: Absent-Parent Questions and Assignment of Rights

For office use only. Head of household name: _____ Head of household SSN: _____

Please read Part A of Supplement C (page 7) before you fill out Parts B, C, and D of Supplement C (below).

Absent Parent (cont.)

ABS

PART B—Good Cause

Is there any reason (Good Cause) not to help us get medical support from an absent parent? . . . . . ☐ yes ☐ no

If **no**, fill out PART C—Absent-Parent Information—below.
If **yes**, list the name(s) of the child or children whose absent parent(s) you do not want to give us information about, and check one of the boxes below for the reason that applies to the child or children.

Name(s): _____

- ☐ **Cooperation could result in serious physical or emotional harm to a family member or his or her child, or the applicant or member.**
- ☐ **Adoption of the child is in process.**
- ☐ **The child was a result of sexual abuse or assault.**

Name(s): _____

- ☐ **Cooperation could result in serious physical or emotional harm to a family member or his or her child, or the applicant or member.**
- ☐ **Adoption of the child is in process.**
- ☐ **The child was a result of sexual abuse or assault.**

PART C—Absent-Parent Information (if known)

1.

Name	Social security number*	Date of birth / /	Sex ☐M ☐F
Address		Telephone number ( )	

Is there a medical-support order? . . . . . ☐ yes ☐ no

Relationship to child: ☐ Mother ☐ Father ☐ Other: _____ Driver's license number:* _____

Names of children of this absent parent: _____

Name and address of absent-parent's employer: _____

_____

Required, if obtainable and one has been issued.

2.

Name	Social security number*	Date of birth / /	Sex ☐M ☐F
Address		Telephone number ( )	

Is there a medical-support order? . . . . . ☐ yes ☐ no

Relationship to child: ☐ Mother ☐ Father ☐ Other: _____ Driver's license number:* _____

Names of children of this absent parent: _____

Name and address of absent-parent's employer: _____

_____

Required, if obtainable and one has been issued.

PART D—Signature

I am the parent whom the child lives with (custodial parent) or legal guardian, and I understand that by signing below I assign my rights and give permission to MassHealth and DOR to go after medical support from the absent parent of any child under age 19 who is living with me and applying for MassHealth. I also agree to cooperate with MassHealth and DOR in this process, as explained in PART A—Cooperation—of this supplement.

**Signature of custodial parent or legal guardian: _____ Date: _____

***Required, only if you are applying for yourself and the child who is living with you.*

If you need more space, please use a separate sheet of paper, and attach it to this supplement.

Supplement D: Questions for Immigrants

For office use only. Head of household name: _____ Head of household SSN: _____

Leave this page blank if you answered YES to the immigration question on page 3.

Fill out this page if you answered NO to the immigration question on page 3.

1. Are you or any family member on active duty, or a veteran of the United States Armed Forces with an honorable discharge, or did you or any family member serve under U.S. command during World War II or in Vietnam? . . . . . ☐ yes ☐ no
   If **yes**, you may stop here.
   If **no**, go to the next question.
2. Are you or any family member the spouse, widow or widower, or dependent of a person on active duty or a veteran described above? . . . . . ☐ yes ☐ no
   If **yes**, you may stop here.
   If **no**, go to the next question.
3. Are you or any family member a victim of domestic abuse and **no longer living with the abuser**? . . . . . ☐ yes ☐ no
   If **yes**, you may stop here.
   If **no**, you must fill out the rest of this page *(Immigration Status)*.

Immigration Status

QAC

Fill out the chart below for each member of the family who is **not** a U.S. citizen and who is applying for MassHealth. List *all* statuses that have applied to each person since that person entered the U.S.

Send copies of both sides of all immigration cards (or other documents that show immigration status).
See the MassHealth Member Booklet for a more complete description of immigration statuses.

Note: Family members who are applying for only MassHealth Limited and/or CMSP or Healthy Start do not have to give us a social security number. We will not match their names with any other agency including the Department of Homeland Security (DHS). You do not need to list their names on this page or send proof of their immigration status. But you must list their names in the orange block on page 3. MassHealth Limited pays for emergency services only. See the MassHealth Member Booklet for more information.

Use these codes to describe your status in the chart below:

4. Amerasian admitted pursuant to Section 584 of Public Law 100-202
5. Granted asylum
6. Conditional entrant
7. Cuban/Haitian entrant
8. Deportation withheld
9. Legal permanent resident
10. Native American with at least 50% American Indian blood born in Canada
11. Granted parole
12. Refugee
13. Person with a temporary visa/other
14. Person residing under color of law (PRUCOL) *(See the MassHealth Member Booklet for more information.)*
15. Victim of severe forms of trafficking

Name	Status codes (List all that apply.) a	b	c	d	Date status awarded a	b	c	d	U.S. entry date	**For office use only**
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If you need more space, please use a separate sheet of paper, and attach it to the application.

Did you remember to:

- Read the instructions on the instruction page?
- Fill out a separate application for each family group?
- **Answer all questions, and fill out all sections and any supplements that apply to you and your family?** You do not have to send back any supplements that do not apply.
- Sign and date the application on page 4? Remember, the head of household, all applicants aged 18 or older, and all parents of any age who have children living with them must sign.
- Submit a filled-out MassHealth Eligibility Representative Designation Form, if you are filling out this application as an eligibility representative or if you want someone to act on your behalf?
- Send proof of all income, like copies of two recent pay stubs, copies of any benefit checks or award letters, or copies of your most recent federal tax return with schedules?
- Send proof of your HIV-positive status only if you want to see if you might be eligible for MassHealth because you are HIV positive? MassHealth may give benefits to people who are HIV positive who might not otherwise be eligible. If you apply because you are HIV positive, and do not give us proof of your HIV-positive status now, we will need to send you a letter asking for this proof. The letter will be sent to the address you gave us on this application. Proof can be a letter from your doctor, clinic, lab, or AIDS service provider or organization that shows the name of the person who is HIV positive and his or her positive test result.
- Send a copy of both sides of all immigration cards (or other documents that show immigration status) for every family member who is **not** a U.S. citizen and who is applying? (See Supplement D.)
- Send a copy of both sides of all health-insurance cards for every family member who has insurance?

Please staple, clip, or attach all needed papers to your application.

When you have filled out and signed this application, send it with all other needed papers to:

MassHealth Enrollment Center
Central Processing Unit
P.O. Box 290794
Charlestown, MA 02129-0214